

WOMACK ARMY MEDICAL CENTER

Scrub Application

The proponent agency is MCXC-DOL-MB

PLEASE PRINT CLEARLY

User Last Name _____

User First Name _____

Hospital Badge # _____

Phone Extension _____


Personal Identification Number

PIN - 4 Digits (if not completed, a PIN will be assigned)

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Front of Badge

Picture





Please choose one of the following for Occupation and one for the Department:

Occupation

<input type="checkbox"/>	Anesthesia Services
<input type="checkbox"/>	BMAR
<input type="checkbox"/>	Contractor
<input type="checkbox"/>	Nurse
<input type="checkbox"/>	Perfusion
<input type="checkbox"/>	Pharmacist
<input type="checkbox"/>	Physician
<input type="checkbox"/>	Physician / Assistant
<input type="checkbox"/>	Resident
<input type="checkbox"/>	Respiratory Therapy
<input type="checkbox"/>	Staff
<input type="checkbox"/>	Student
<input type="checkbox"/>	Surgeon
<input type="checkbox"/>	Technician
<input type="checkbox"/>	Other (specify) _____

Department

<input type="checkbox"/>	Cardio Cath Clinic
<input type="checkbox"/>	Central Sterile Supply
<input type="checkbox"/>	Dept. of Family Medicine
<input type="checkbox"/>	Dept of Medicine
<input type="checkbox"/>	Dept. of Pediatrics
<input type="checkbox"/>	Engineering/Bio Med
<input type="checkbox"/>	Environmental Service
<input type="checkbox"/>	GI Clinic
<input type="checkbox"/>	Labor & Delivery
<input type="checkbox"/>	Mother Baby Unit

<input type="checkbox"/>	NICU
<input type="checkbox"/>	OR
<input type="checkbox"/>	Oral Surgery
<input type="checkbox"/>	PACU
<input type="checkbox"/>	Pathology
<input type="checkbox"/>	Radiology
<input type="checkbox"/>	Urology Clinic

Other (specify) _____

Sizes: Choose your appropriate size

<input type="checkbox"/> Small	<input type="checkbox"/> Large	<input type="checkbox"/> 2X
<input type="checkbox"/> Medium	<input type="checkbox"/> X-Large	<input type="checkbox"/> 3X

THIS AREA TO BE COMPLETED BY MANAGER / DIRECTOR

Please select the appropriate machine for access

Dispenser Location

<input type="checkbox"/>	A. OR Male
<input type="checkbox"/>	B. OR Female
<input type="checkbox"/>	C. L&D
<input type="checkbox"/>	D. 2nd Floor Common Area

Number of Credits

1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
3.	<input type="checkbox"/>

Expiration Date for STUDENTS

Authorizing Signature- Department Chief / Phone Number

Authorizing Signature- Linen Department

Date _____

ACCESS CONTROL BADGE FORM

The proponent agency is (MCXC-PTMS)

1. Request the individual identified below be issued an access control badge with access to the areas listed in section 6

2. Demographic Information

LAST NAME _____

FIRST NAME _____ MIDDLE INITIAL _____

RANK _____

TITLE _____

DEPARTMENT: _____

TELEPHONE: _____

3. Supervisor Name (Print) _____

Supervisor Signature _____

4. Job Status: ☐ Military ☐ Civilian ☐ Contractor ☐ Student ☐ Volunteer

5. Badge Status: ☒ New Badge ☐ Replacement Badge ☒ Temporary Badge ☐ Change Access Level

Time Period: _____

ACCESS CONTROL

6. Department Information: OIC/NCOIC/Designated individual of each department are authorized to sign as Approving Authority:
Approving Authority from each department where access is required must sign below

A DEPARTMENT _____
ACCESS CONTROL LEVEL MASTER LEVEL II _____

Authorized By Approving Authority: _____

B DEPARTMENT _____
ACCESS CONTROL LEVEL _____

Authorized By Approving Authority: _____

C DEPARTMENT _____
ACCESS CONTROL LEVEL _____

Authorized By Approving Authority: _____

Signature _____

SECURITY PERSONNEL USE ONLY

ACCESS BADGE NUMBER _____ DATE ISSUED _____

DATA ENTERED BY _____